Flexible Spending Account
Debit Card

Do you use a large portion of your Health Care Flexible Spending Account (FSA) for prescription drug purchases? If so, you may want to consider signing up for the Debit Card.

HOW DOES THE DEBIT CARD WORK?

- This card can be used **only** for prescription drug purchases.
- You present the card when you **order** your prescription from the pharmacist.
- Your prescription is paid for with your Health Care FSA funds when you pick up your prescription.
- No paper claim form is required.

BEFORE YOU ORDER THE CARD:

- Consider that you will pay the $.85 each paycheck (by payroll deduction) for the cost of this card.
- Make sure your pharmacy is a participating pharmacy by visiting www.usscript.com/index.html and click on "participating providers." Enter 4800 in the Group ID field & your zip code in the appropriate field. After you receive the search results, review the listing for participating providers in your area.
- The card will only work at the pharmacies who participate in this program. If your pharmacy is not listed, do not apply for the card.

TO REQUEST THE DEBIT CARD

- Complete the enclosed Card Application.
- Return the completed application to:
  ASI
  P O Box 6044
  Columbia, MO 65205-6044
  or
  fax it to: 573-874-0425
- You will receive your debit card at your home address within approximately 3 weeks from the date requested.

USING YOUR DEBIT CARD

- Present your Debit Card to the Pharmacist when you order the prescription. If you wait to present your card until you pick up your prescription, it will not be accepted.
- You will receive a paper card (from ASI) to show to your pharmacist that instructs him/her on how to set up your card number in the pharmacy computer. (It is important that the debit card number be entered into the pharmacy terminal as a secondary payor. Your insurance company is the primary payor.)

Customer Service 800-659-3035
Fax 573-874-0425 (toll call)
asi@asiflex.com
PO Box 6044
Columbia MO 65205-6044

-OVER-

DEBIT CARD APPLICATION
FOR HEALTH CARE FLEXIBLE SPENDING ACCOUNT USE ONLY

Your employer, through ASI, is offering an optional Debit Card to be used for prescription drug purchases at participating pharmacies. By using this card, your cost for prescription medications will be taken directly from your Flexible Spending Account and will eliminate the need to fill out a paper claim form with ASI for those purchases. The card is strictly optional and there is an additional cost for this service.

The Flexible Spending Account Prepaid Card may only be used at participating pharmacies. Please review the information on the other side of this form for "Before you Order the Card".

To apply for the prepaid card please fill in the shaded area below and mail or fax to ASI.

Name: _____

Employer: _____

Social Security Number: _____

Date of Birth: _____

ALL FIELDS ARE REQUIRED FOR CARD ISSUANCE.

By signing below the applicant agrees that he/she is enrolled in the employer's health care flexible spending account program. The applicant agrees to pay $.85 per paycheck for the ability to use the Flexible Spending Account Debit Card. The prepaid card is strictly optional and is not required to take advantage of the benefits offered through your employer's Flexible Spending Account program.

Prescription medications may be purchased using the prepaid card provided they are a qualifying expense and funds are available in your health care flexible spending account. You will not need to submit claims by mail or fax for accepted transactions. However, the card will not be accepted if there are not funds available to cover your full cost of the prescription.

To cancel the card you will need to notify ASI of your intent to cancel the card 15 days prior to the cancellation date. ASI will turn the prepaid card off as soon as possible from the date of notice to allow previously submitted claims to be processed. The $.85 per paycheck fee will be charged if the card is available for any part of a calendar month.

I hereby authorize and direct my employer to reduce my salary by $.85 per paycheck to pay for the optional benefit shown above in accordance with my employer's Flexible Benefits Plan, Section 125. Such reductions, considered as elective contributions under the plan, shall commence within the payroll cycle in which this election is received by my payroll center.

Employee's signature _____ Date _____

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